Improving fundamental care in hospitals: how priority setting drives research
Working with patients, public and service to identify priorities

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Rationale for Priority Setting

• CLARHC funding for 3 years of research

• Theme and staff set, but scope for theme project

• Adapted existing methods for priority setting

• Identify & prioritise issues for research to improve fundamental care in hospitals
Methodology

1. Conceptual framework - possible 'themes' identified from reports/literature
2. Consultation: survey & groups/meetings
3. Content analysis of responses
   76 topics (178 subtopics) identified
4. Analysis to identify topics - most frequently referred to (15)
5. 'Voting' at workshop (5)
6. Develop research ideas
Fundamentals of Care

• Nursing theory – Activities of Daily Living
• Department of Health – Essence of Care
• Patients perspective – measuring patient experience
• Effective delivery – staff view of what is most important to deliver care well
• Organisational factors – staffing, management, resources
• Outcomes/metrics – measuring the effect of what has been done
Pre-workshop engagement
# Short-list

<table>
<thead>
<tr>
<th>Patient needs</th>
<th>Point of care</th>
<th>Staffing/organisation</th>
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</thead>
<tbody>
<tr>
<td>Individualised care/patient centred care (action)</td>
<td>Nurse staffing</td>
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<tr>
<td>Staff attitudes/relationships with patients</td>
<td>Training/ updating skills/CPD</td>
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<td>Staff communication</td>
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<td></td>
<td>Working relationships/Team work</td>
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<td></td>
<td>Ward management/leadership</td>
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</table>

- **Bladder & bowel related care/toileting**
- **Eating & drinking (hydration & nutrition)**
- **Prevention & management of pain**
- **Skin care (avoidance of pressure ulcers)**
- **Safety and avoiding patient harms**
- **Information about care/communication with pts**
- **Maintaining patient dignity**
- **Monitoring condition/vital sign observations**
The Priorities

• 1. Nurse staffing
• 2. Individualised patient care
• 3. Staff communication
• 4. Staff attitudes and relationships with patients
• 5. Information about care/communication
What next...
Mapping Research to Priorities
Nurse staffing research: programme overview

Professor Peter Griffiths

Workforce Research Group / NIHR CLAHRC Wessex
How to respond to priorities....?

- Mapping existing research to priorities
- Identify evidence gaps
- Develop future research
Welcome
Mid Staffordshire NHS Foundation Trust provides healthcare for people in Stafford, Cannock, Rugeley and the surrounding areas, serving a local population of over 300,000 people.

The Trust manages two Hospitals, at Stafford and Cannock.

Latest News
'Mid Staffs Star' Award Launched by Trust to Recognise Outstanding Staff
22 June 2011
The Trust has launched an awards scheme - the ‘Mid Staffs Star’ - to recognise and reward best practice at both its hospitals.

We welcome visitors and appreciate that your support can play a vital role in your relative or loved one's recovery.

Most of our wards have a two hour visiting slot in the afternoon and again in the evening. Please check the times for each ward below.

Help us to fight infections, use the alcohol gel to clean your hands before you enter and after you leave the ward.

‣ Visiting Times
‣ Parking

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"400 to 1200 excess deaths?"
Evidence for the association between nurse staffing levels and patient outcomes

• “...compelling...”
  – (UK Royal College of Nursing, 2010)

• “...overwhelming...”
  – (US Joint Commission, 2005 p105)
NICE Safe staffing guideline (SG1) 2014

• “There is a lack of high-quality studies exploring and quantifying the relationship between registered nurse and healthcare assistant staffing levels and skill mix and any outcomes”
Key gaps

• High quality studies quantifying the relationship between registered nurse and HCA staffing levels / skill mix in a UK context
  – Staffing levels
  – Direct linkage (cause / effect)
• Toolkits / staffing methodologies
• Approaches to organizing care delivery
• Non safety outcomes
• Organisational policies / practices / procedures
Our ongoing research programme
Does missed care mediate the relationship between staffing levels and outcomes?

- Secondary analysis of cross sectional data from RN4CAST
- Nurse reported clinical ‘care left undone’ partially accounts for the relationship between low nurse staffing levels and increased mortality
- Supports ‘missed care’ as a nursing indicator
- (PhD study, Jane Ball @ Karolinska Instutet – submitted for publication)
Nurse staffing levels, missed vital signs observations and mortality in hospital wards (HS&DR 2015-2017)

- modelling the consequences and costs of variations in nurse staffing and skill mix at ward level
- explores the effect of specific staffing levels on different ward types
- Improve causal inference
  - because it measures prospect relationships
  - by measuring a key mechanism (timely observation)
- Missed care as a possible quality indicator?
- Headline finding mortality & missed vital signs observations are increased when patients are exposed to staffing below planned level for ward....
Shift patterns (NIHR CLAHRC studentship)

- Association between nurse shift patterns (including 12 hour shift)
  - Job performance (measured by vital signs compliance)
  - Sickness / absence
  - Costs

Shows rates of nurse sickness / absence increased with more 12 hour shifts... using objective data for the first time,

Has implications for costs and nurse well being

Effect on job performance coming soon (completing summer 2017)
Nurse staffing and Quality of Interactions

• A secondary analysis of data from the study “Creating Learning Environments for Compassionate Care” (pilot trial – HS&DR funded)

• Is there an association between nurse staff levels / skill mix and the quality of interpersonal care...

• Headlines
  
  – Negative interactions increase when staffing levels are lower
  
  – While the negative interactions are not associated with any particular staff group, findings suggest that problems rise sharply when skill mix is low
Modelling the costs and consequences of using the Safer Nursing Care Tool (Shelford Tool HS&DR funded – End 2018)

- Determine the costs / consequences of staffing to tool recommendations
- Model the feasibility & costs of different approaches to setting base staffing levels
- Explore flexible staffing models to meet varying patient need
- Provides a first independent validation of the tool
Implementation, impact and costs of policies for safe staffing in acute trusts (PRP funded, reports end 2018)

- Describe how post Francis safe staffing policies have been implemented locally & nationally

- Determine the associated costs of policy implementation:
  - Mixed methods study using a national survey, routine data and in-depth analysis in 4 case study trusts...
  - Includes economic evaluation & realist evaluation to generate theory about policy implementation

  - “What works, for whom, in what respects, to what extent, in what contexts, and how?”
Conclusions

• Staffing research was NOT a priority for future CLAHRC projects
Sources / additional info – recent papers from Southampton team (post NICE)


Improving Fundamental Care in Hospitals

Lisette Schoonhoven

Professor of Nursing

Collaboration for Leadership in Applied Health Research and Care (Wessex)
The priorities

1. Nurse staffing
2. Individualised patient care
3. Staff communication
4. Staff attitudes and relationships with patients
5. Information about care/communication
Evidence

• Lack of evidence
• Common sense solutions without evaluation
• Incomplete implementation
• Lack of theory
Fundamental care

Is generic across medical conditions and care settings
Serves next to all people in their lifetime
Synonyms: essential care, basic care
Fundamental care is not simple and easy
• Complex interplay between physical, psychosocial and relational elements (Kitson et al 2013)
• Example: elimination

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<tr>
<th>Physical</th>
<th>Psychosocial</th>
<th>Relational</th>
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<tr>
<td>Use of devices and equipment to support elimination</td>
<td>Self-esteem, dignity, humiliation</td>
<td>Respect and support to maintain sense of dignity and self esteem</td>
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Patient centred care

The ladder of participation

- **FULL CONTROL**: Service users control decision making at the highest level.
- **SHARING POWER**: Service users share decisions and responsibility, influencing and determining outcomes.
- **PARTICIPATION**: Service users can make suggestions and influence outcomes.
- **CONSULTATION**: Service users are asked what they think but have limited influence.
- **INFORMATION**: Service users are told what is happening but have no influence.
- **NO CONTROL**: Service users are passive consumers.

Source: Adapted from Arinstein's A Ladder of Participation, Hart & Groundswell.
Improving fundamental care

Patient-staff relationship

Patient participation and involvement

Evidence based care

Tailoring

Ward level conditions

Patient centred care
Poor fundamental care associated with adverse outcomes

Pressure ulcer prevention
1. Range of fundamental care activities
2. Major burden
3. Expertise
Creating Learning Environments for Compassionate Care (CLECC)

• Focus on developing leadership and team practices that enhance team capacity to provide compassionate care
• Aims to develop and embed sustainable manager and team practices:
  – Dialogue
  – Reflective learning
  – Mutual support
• 3 month training programme
  – Practice educator will facilitate
  – Classroom training
  – Training on the job (cluster discussions, reflective discussions)
  – Monthly ward manager action learning sets
Tell-Us card

- Uncomplicated, structured tool to invite patients to write down their goals/preferences for care
Tailoring

- Use of algorithm to support decision making
- Include risk factors
- Patient’s needs and preferences are missing
Intervention

Ward level conditions (CLECC)

Patient-staff relationship (CLECC)

Patient participation and involvement (Tell-Us Card)

Evidence based care (Guideline)

Tailoring (PrevPlan)

Patient centered care for PU related fundamental care activities
Methodology

• **Work package 1:** To adapt PrevPlan and the Tell-Us Card to ensure they incorporate patient preferences with guideline recommendations for pressure ulcer prevention and deliver a care plan that can be used by patients, carers and nursing staff in the UK context.
  
  – Extending Prev-Plan: mobility, skin care, continence and nutrition
  – Developing patient information
  – Co-development of interventions (working groups)
    • *Gaining understanding*
    • *Testing prototypes*
    • *Polishing final version*
Methodology

- **Work package 2:** To determine the feasibility and acceptability of the combined use of CLECC, PrevPlan and the Tell-Us Card to patients, carers and nursing staff.
  - 2 trusts, 6 wards
  - 3 months implementation period
  - Observations, surveys, interviews
Methodology

- **Work package 2**: To determine the feasibility and acceptability of the combined use of CLECC, PrevPlan and the Tell-Us Card to patients, carers and nursing staff.
  - Outcomes:
    - Patient perception of patient-centredness of care
    - Nurses’ perception of patient-centredness of care
    - Quality of staff-patient interactions
    - Relevant fundamental care activities
    - PU & Cost (secondary)

- Project will run until end of 2018
Team

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• Professor Jackie Bridges
• Ms Ewa Crunden
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• Professor Peter Griffiths
• Dr. Jo Hope
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• Professor Carl May
• Dr. Greta Westwood
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Questions?